Exhibit 7
Experience Data Reporting
Instructions for Basic Health and Health Coverage Tax Credit

The information that you are about to provide is vital to HCA. The Basic Health (BH) program will use this data to better understand utilization and healthcare cost trends for our population. It is essential that the data you submit be accurate. Please be sure to follow the definitions provided within this document when completing the worksheets.

General Procedures

The following are general instructions for completing the required reports. The primary objective of these instructions is to promote uniform reporting by all health plans.

Health plans will complete Experience Worksheets based on each health plan's financial and utilization experience with BH enrollees. Note that some of the reports require the information reported to be broken out between BH and Health Coverage Tax Credit (HCTC).

This document also contains detailed, standardized definitions of the medical service categories contained in the worksheets. Health plans will use these standardized service category definitions to report their experience. HCA, in conjunction with their consultants, have provided health plans with sufficient detail so that the line items of the exhibits can be completed accurately. This assures that the data received will be as consistent as possible from health plan to health plan. The data reported by service category must be mutually exclusive and non-duplicating.

Each health plan must provide an Actuarial Memorandum signed by a Qualified Actuary. The memorandum must address the following issues:

1. Claim costs have been reviewed for reasonableness and reconciled to calendar year 2010 financial statements. While the reported experience will not balance exactly to the OIC financial statements for a variety of reasons, the actuary should understand and be comfortable with the sources of those differences.
2. Claim costs reflect best estimates of incurred experience for CY 2010, with no reserve margins.
3. Claim costs reflect all offsets, such as third party recoveries and pharmacy rebates.
4. Administrative expenses reflect the Basic Health block of business to the extent possible.
5. Administrative expenses include no risk margins or profits.

Reports are due March 31, 2011 for incurred experience in the prior calendar year.

Reports must be submitted to the following e-mail address:
hcabhprocurement@hca.wa.gov

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REPORT 1 – DETAILED INCOME STATEMENT

Report revenues and expenses using the full accrual method according to GAAP.

A. Revenue

Capitation – Capitation Revenue recognized on a prepaid basis for provision of health care services for eligible participants. Capitated revenue PMPM should be calculated using the same denominator for member months that is used for all other PMPM line items.

Other Income – Revenue from sources not identified in other revenue categories such as investment income.

B. Incurred Medical Expense

All expenses must be reported, net of offsetting reimbursement, such as Medicare payments, other TPL or pharmacy rebates.

Hospital Inpatient – This expense category covers daily room and board and ancillary services in short-term hospitals. Ancillary services include use of surgical and intensive care facilities, inpatient nursing care, pathology and radiology procedures, drugs and supplies. The ancillary charges do not include any professional charges (including professional charges for physicians on staff at the hospital).

Costs also include daily room and board and ancillary services in an approved nursing facility, including a skilled nursing facility. The care could be provided in either a nursing bed in a hospital or an independent skilled nursing facility. Confinements must be medically necessary; confinements related solely to custodial care are not included. Ancillary services include inpatient nursing care, pathology and radiology procedures, drugs and supplies.

Emergency Room services preceding a hospital inpatient admission should be included in the Hospital Inpatient category.

ER (Emergency Services) – This expense category covers services for outpatient emergency accident and medical care performed in the emergency area of a hospital outpatient facility. Costs include facility charges only and do not include professional charges unless performed by full-time staff of the facility and not billed separately.

Other Outpatient – This expense category covers hospital outpatient services (excluding emergency room services) performed in a hospital outpatient facility or a freestanding facility such as surgery, radiology, pathology, pharmacy and blood, cardiovascular, and PT/OT/ST. Costs include facility charges only and do not include professional charges unless performed by full-time staff of the facility and not billed separately.

Professional – This expense category covers the charges for medical treatments done by a qualified professional and not otherwise included above. Include all professional

fees for inpatient and outpatient services when billed separately from the facility charge, services by anesthesiologists, office visits, home visits, consultations, the professional components of radiology and pathology services when performed in a hospital or freestanding facility, global radiology and pathology charges when performed in an office or clinic setting, private duty nursing, chiropractor, podiatrist, naturopathy, and PT/OT/ST services performed in an office setting.

RX (Pharmacy) – This expense category covers the charges for prescription drugs. Costs include material charges only and do not include professional charges or prescription drugs included in a facility charge.

Other (Specify) – Those outpatient expenses not specifically identified in one of the categories defined above. Note: This category should only be used if the expense cannot be allocated to one of the predefined categories. Examples include ambulance, durable medical equipment, prosthetics, and risk payments not considered as capitated payments. Capitated expenses covering services in the categories listed above should be allocated accordingly and should not be placed in the Other category.

C. Incurred Claim Allocation

The incurred claim subtotal (from Part B) should be allocated such that it equals paid claims plus ending reserves less beginning reserves for the requested experience period.

Beginning Reserves – Total medical expense reserves as of the start date of the requested experience period.

Paid Claims – Claims paid during the requested experience period. This includes capitation, fee-for-service, and provider risk payments.

Ending Reserves – Total medical expense reserves as of the end date of the requested experience period.

D. Other Claim Information

Reinsurance Premium Paid – Reinsurance Premium Expense.

Reinsurance Recoveries – Amounts recovered and recoverable from reinsurers on losses incurred during the experience period.

Third-Party Liability (TPL) Recoveries – Include all third party cost offsets.

E. Administrative Expense

Administrative expenses must include all administrative costs associated BH enrollees incurred by the contracted plan.

Rent – Occupancy expenses incurred, such as rent and utilities, on facilities used to deliver health care services to participants as well as administrative facilities. Deduct rent under sublease and exclude items for health care delivery.

Salaries, Wages, and Other Benefits – This includes all forms of compensating employees including salaries and wages, bonuses, benefits, payroll taxes, payments under a program for pension, stock options, purchases, etc. to personnel.

Legal Fees and Expenses – Fees paid or payable by the health plan for the current period for court costs, penalties and all fees or retainers for legal services or expenses in connection with matters before administrative or legislative bodies. Exclude salaries and expenses of company personnel, legal expenses associated with investigation, litigation and settlement of policy claims, and legal fees specifically associated with real estate transactions.

Marketing and Advertising – Expense related to any medium of exchange whereby the intent of such medium is to promote or increase a health plan's enrollment such as newspaper, magazine and trade journal advertising, television or radio broadcasting, and mailings. Exclude outreach activities designed to inform existing participants of their benefits.

Outsourced Services – Management fees paid or payable by the health plan for the current period to an outside management company as well as costs for outside data processing services during the period.

Other Expenses (Specify) – Those administrative expenses not specifically identified in the categories above such as interest expense, depreciation on assets not used to deliver health care services to participants, or internal data processing (other than compensation).

Premium Tax – Exclude any portion of allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

F. Total Expenses

Equal to total incurred medical expenses plus total administrative expense.

G. Income (Loss) Before Income Taxes

Total revenue less total expenses.

REPORT 2 – EXPERIENCE BY COUNTY

County is defined by subscriber residence.

Members – The member months should be reported on a cumulative basis by coverage group. A member (participant) is an eligible person who has been enrolled with a health plan for the provision of health services. A member month is equivalent to

one (1) member for whom the health plan has recognized capitation-based revenue for the month. The number of member months should correlate to the number of capitated payments received.

Revenue – Revenue includes capitation revenue. It is not necessary to allocate other revenue by county for this report.

Capitation - Includes incurred capitation expenses to providers for the requested experience period.

Fee-For-Service Paid – Includes fee-for-service expenses incurred during the requested experience period.

Other - Includes any risk or incentive payments incurred during the experience period.

REPORT 3 – TREND MONITORING REPORT

The claims included in Report 3 should be consistent with the OIC Service Categories of Medical/Hospital, Professional and Rx.

Members – A member (participant) is an eligible person who has been enrolled with a health plan for the provision of health services. The number of members should correlate to the number of capitated payments received.

Capitation - Includes incurred capitation payments to providers for the members for each given month and year.

Fee-For-Service Paid – Includes incurred fee-for-service costs the given month and year.

Other - Includes any risk or incentive payments incurred during the three year period. Please disclose any allocation method used to spread payments by month.

Estimated Incurred – Equals capitation plus fee-for-service plus other.

Estimated Incurred PMPM – Estimated Incurred divided by Members for each month.

REPORT 4 – HIGH COST MEMBERS REPORT

For the requested experience period, report all members with incurred claims in excess of $100,000 for each of the four coverage groups. Member identification must be scrambled. The individuals will not be re-identified.

REPORT 5 – UTILIZATION SUMMARY

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Utilization statistics per 1,000 should be consistent with the incurred claims included in Report 1. Include capitated and fee-for-service experience. Separate delivery utilization from other inpatient statistics. As with Report 1, Emergency Room visits should not include encounters leading to an inpatient admission.